

3 CARRIER'S CASE REPORT**CLAIMANT NAME AND ADDRESS**

Daniel Backman
 94-872 Lumiholoi Street
 Waipahu, HI 96797

WC-1 (Rev. 3-92)		
Case No. 79900534(H)		
FOR OFFICE USE ONLY Date Received		
Mo.	Day	Year
Carrier Case No. 2J029128		
Carrier I.D. 1110		

SOC. SEC. No. 576-84-6611DATE OF INJURY/ILLNESS: 07/31/97EMPLOYER First Insurance Co. of HI, Ltd.CARRIER Continental Casualty CompanyADJUSTER RSKCoADDRESS P.O. Box 1320
Honolulu, HI 96807-1320INDIVIDUAL TO CONTACT James MatsonTELEPHONE NO. (808) 532-3232**CHECK ONE**

1. ☐ DATE OF FIRST INCOME REPLACEMENT PAYMENT: MO. DAY YR.
2. ☐ REOPEN CASE
3. ☐ HEARING REQUESTED
4. ☐ NO LOST TIME/MEDICAL ONLY PAYMENT DATE: MO. DAY YR.
5. ☐ FINAL PAYMENT TO PREVIOUSLY ENDED CASE FOR 19
6. ☒ YEAR END REPORT FOR 20 00
7. ☐ FINAL REPORT (COPY TO EMPLOYEE) FOR 19

NOTE: WHEN 4, 5, 6, & 7 ARE CHECKED, PAYMENT BLOCK MUST BE FILLED IN.

RETURN TO WORK DATE

 MO. DAY YR.

WEEKLY COMP. RATE \$501.00

BENEFIT PAYMENTS	Days	Payments Not Previously Reported	Prior Payments	Total Payments Made to Date
1. Temporary Total	354	\$ 25336.28	\$ 11666.14	\$ 37002.42
2. Temporary Partial		\$	\$	\$
3. Permanent Total		\$	\$	\$
4. Permanent Partial		\$	\$	\$
5. Death		\$	\$	\$
6. Disfigurement		\$	\$	\$
7. Medical/Other Costs		\$ 26275.66	\$ 17650.50	\$ 43926.16
8. Services of Attendant		\$	\$	\$
9. Rehabilitation		\$	\$	\$

Carrier's Comments: TTD: 01/18/00 - 01/20/00; 01/31/00 - 01/15/01

*List Date(s) of Disability in Carrier's Comments Section.

NOTICE TO EMPLOYEE: With the final payment of compensation (as indicated hereon) on your industrial injury of , identified as Case No. , the case shall be closed. This determination shall not constitute a bar to your reopening rights as provided by Section 286-89, HRS, nor to future medical benefits.

Medical Deductible:

I hereby certify the accuracy of all the above statements.

SIGNATURE *James Matson*POSITION: Claims ExaminerDATE: 01/22/018 07 07

EXHIBIT 7